DRUG CRITERIA and LIMITS

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Explanation of Medicaid Policy

Drugs with Criteria and Limits

Many drugs in the Medicaid pharmacy program do not require a Prior Authorization (PA), but are still subject to restrictions that are outlined in the Medicaid Pharmacy Services Manual and the Medicaid Physician Services Manual. This section serves as a quick reference for the specific policies that govern coverage of these drugs.

In accordance with the Utah Medicaid Provider Manual for Pharmacy Services, SECTION 2, Chapter 4-9, Limits on Certain drugs, some drugs are limited by a quantity in any thirty-day period. These drugs do not qualify for early refills, as stated in Chapter 4-7, Early Refills. The limits listed are those approved by the Medicaid Drug Utilization Review (DUR) Board. Physicians and other prescribers who feel that a patient has specific needs that exceed the limits may appeal to the DUR Board. All medications remain subject to all the other requirements of the Utah Medicaid Pharmacy Program, as described in the Utah Medicaid Manual for Pharmacy Services.

All injectable products, with the exception of 10ml insulin vials, are non-covered under PCN.

Drugs Requiring Prior Authorization

In accordance with the Utah Medicaid Provider Manual for Pharmacy Services, SECTION 2, Chapter 3, certain drugs that are covered by the Medicaid program may require the patient and physician to meet specific criteria and demonstrate medical necessity in order to receive the requested medication. Detailed information regarding prior approval criteria for individual medications and classes of medications is provided in this manual.

Please note that prior authorization for a medication is client specific, pharmacy specific, and product specific. Prior authorization cannot be transferred to another pharmacy, to another product, nor to another strength of a product that has been approved. The prior authorization cannot be transferred to another client.

To initiate a prior authorization request, the physician must gather all of the records that are requested in the criteria set for the medication being prescribed. These records should then be faxed, along with a cover sheet that includes the client's name and client ID, physician's name and telephone number, and (if known) the name and telephone number of the pharmacy that the client would like to use. A fax cover sheet that can be filled out with the requested information is included in the back of the prior authorization section, should you wish to use it. The requests can be faxed to (801) 536-0477.

Exceptions to Policy

All requests for exceptions to policy require a petition to the DUR board. DUR meetings are held on the second Thursday of every month. Petitions to the DUR board must be received one week prior to the monthly meeting. Petitions may be faxed to the prior authorization team.

Drugs with Criteria and Limits

ADD/ADHD Medications • Amphetamines	Amphetamines: • Age 0-2: Not a covered benefit. • Age 3-5: Immediate-release Adderall and Dexedrine generic formulations are covered - Valid ICD-9 code must be written on the prescription. • Age 6-18: Covered - Valid ICD-9 code must be written on the prescription. • Age 19+: Prior Authorization Required - see page 21.
• Methylphenidate & Derivatives	Methylphenidate & Derivatives: • Age 0-5: Not a covered benefit • Age 6-18: Covered - Valid ICD-9 code must be written on the prescription. • Age 19+: Prior Authorization Required - see page 21. • Daytrana patch is not covered.
• Strattera	Strattera: • Covered for ages 6+. • Cumulative limit of 66 capsules in 30 days. • Approved as a stand-alone treatment for ADHD.
Analgesics • Celebrex	Celebrex: • Age below 65: Prior Authorization Required - see page 12. • Age 65+: Cumulative limit of 60 capsules in 30 days.
• Tramadol/Ultracet	Tramadol/Ultracet: • Cumulative limit of 180 tablets in 30 days
• Methadone	Methadone • Cumulative limit of 150 tablets in 30 days. • The cumulative limit may be overridden if the prescriber provides a valid ICD-9 diagnosis code for cancer.
• Long-Acting Opioids *(Avinza, Kadian, MS-Contin Oxycontin & generics)*	Long-Acting Opioids • Cumulative limit of 90 tablets in 30 days. • The cumulative limit may be overridden if the prescriber provides a valid ICD-9 diagnosis code for cancer.
• Short-Acting Opioids	Short-Acting Opioids • Cumulative limit of 180 tablets in 30 days • The cumulative limit may be overridden if the prescriber provides a valid ICD-9 diagnosis code for cancer.
• Short-Acting Opioid/APAP	Short-Acting Opioid/Apap Combinations • Cumulative limit of 180 tablets in 30 days • The control is on Acetaminophen and may not be overridden for safety reasons.
Atypical Antipsychotics *(Abilify, Clozaril, Geodon, Risperdal, Seroquel, Sybmbyax, Zyprexa)*	• Valid ICD-9 diagnosis code is required on each prescription. • ICD-9 codes may be found in the Utah Medicaid Provider Manual for Physicians Services and Anesthesiology. • ICD-9 code must be correct for the patients age.
Benzodiazepines	• Cumulative limit of 120 tablets/capsules in 30 days. • Short acting benzodiazepines that are typically used to treat insomnia are governed by the criteria for sedative-hypnotics.

Drugs with Criteria and Limits

Bupropion *(Zyban, Wellbutrin)*	• One of two valid ICD-9 diagnosis codes is required on each prescription. • ICD-9 311 indicates depressive disorders. • ICD-9 305.1 indicates smoking cessation. • Wellbutrin XL is not covered.
Butalbital Containing Products	• Cumulative limit of 30 tablets in 30 days.
Chantix	• Lifetime limit of 24 weeks of therapy.
Cymbalta	• One of two valid ICD-9 diagnosis codes is required on each prescription. • ICD-9 311 indicates depressive disorders. • ICD-9 729.2 for neuralgias, etc. • The maximum daily dose is 60 mg. Monthly quantity limits are set accordingly.
Diphenoxylate Containing Products	• Cumulative limit of 30 tablets in 30 days.

Inhalers	LIMIT IN ANY 30 DAY PERIOD

Effective April 1, 2002, the cumulative number of inhalers in any 30-day period is limited for a Medicaid client. The limit is set by class (excepting Foradil and Serevent which are limited by NDC number). This means the highest number in any one class is the maximum. When there are more than two sizes or strengths for a given product, the limit is based on the largest size or strength. There are two groups of inhalers: oral and nasal. For each group, the limits are stated below.

Inhaler Class	Generic Name	Brand Name	Product Size	Doses per Inhaler	Maximum No. In 30 Days
Nasal Anti-inflammatory inhalers	beclomethasone	Beconase AQ	25	200	2
	fluticasone	Flonase	16	120	1
	triamcinolone	Nasacort AQ	16.5	120	2
	triamcinolone	Nasacort HFA	9.3	100	3
	flunisolide	Nasarel	25	200	3
	mometasone	Nasonex	17	120	1
	budesonide	Rhinocort AQUA	8.4	120	2
Beta 2 agonists and Sympathomimetic Inhalers	Albuterol	generic	17 gm	200	4
		Proventil	17 gm	200	4
		Proventil HFA	6.7 gm	200	4
		Ventolin	6.8 gm	80	4
			17 gm	200	4
		Ventolin HFA	18gm	200	4
	Formoterol	Foradil		12	1
				60	2
	Metaproterenol	Alupent	14 gm	200	2
	Pirbuterol	Maxair	25.6 gm	300	3
	Pirbuterol	Maxair Autohaler	14 gm	400	1

Inhaler Class	Generic Name	Brand Name	Product Size	Doses per Inhaler	Maximum No. In 30 Days
	Salmeterol	Serevent	6.5 gm	60	1
			13 gm	120	1
		Serevent Diskus		60	1
Anticholinergicic Inhalers	Ipratropium	Atrovent HFA	14 gm	200	2
	Ipratropium / Albuterol	Combivent	14.7 gm	200	2
	Tiotropium	Spiriva	30 cap.	30	1
	Beclomethasone	Qvar 40mg	7.3 gm	100	2
		Qvar 80mg	7.3gm	100	2
	Budesonide	Pulmicort Turbuhaler		200	2
	Flunisolide	AeroBid, AeroBid-M	7 gm	100	2
	Fluticasone MDI	Flovent	13 gm	120	1
				120	1
				120	2
	Fluticasone DPI	Flovent Rotadisk 50 mcg, 100 mcg, and 250 mcg		60	1
				60	1
				60	4
	Triamcinolone MDI	Azmacort	20 gm	240	2
	Fluticasone / Salmeterol DPI	Advair diskus 100/50		60	1
		Advair diskus 250/50		60	1
		Advair diskus 500/50		60	1
Mast cell stabilizer Inhalers	Cromolyn MDI	Intal	8.1 gm	112	3
			14.2 gm	200	2
	Nedocromil MDI	Tilade	16.2 gm	112	3

Drugs with Criteria and Limits

Laxatives • Miralax • Lactulose	Miralax: • Cumulative limit of 1054gm in 30 days Lactulose: • Cumulative limit of 6,000ml in 30 days • Over 6,000ml in 30 days requires a prior authorization - see page 16.
Levothyroxine Products	• Generic use mandated when AB-rated equivalent exists • Use the table below to determine appropriate substitutions: Drug — Rating Unithroid — AB1,AB2, AB3 Mylan Levothyroxine — AB1,AB2,AB3 Levoxyl — AB1, AB3 Synthroid — AB2 Levo-T — AB2, AB3

Drugs with Criteria and Limits

Migraine Medications (Tryptans) *(Imitrex, Zomig, Amerge, Axert, Maxalt)*	• Cumulative limit of 9 dosage units per 30 days - all forms count towards this limit. • Examples of drugs in this class include Imitrex, Maxalt, and Zomig.
Muscle Relaxants	• Cumulative limit of 30 tablets in 30 days. • Dantrolene, Baclofen, and Tizanidine are not included in this policy.
Prograf (tacrolimus)	• All oral dosage forms are a covered benefit for use as a prophylaxis of organ rejection in allogenic liver transplants only.
Proton Pump Inhibitors	• Cumulative limit of 30 units in 30 days. • Prior Authorization required for twice daily dosing - see page 18. • Prilosec OTC prescriptions do not require a PA for twice daily dosing.
Sedative-hypnotics for sleep *(Dalmane, Sonata, Somnote, Halcion, Ambien, Doral, Restoril, Lunesta, Rozerem, and their generics)*	• Cumulative limit of 30 units in 30 days. • Benzodiazepines that are typically used to treat insomnia are considered part of this class.

Drugs Requiring Prior Authorization

Anti-Emetics • 5HT3's *(Anzemet, Kytril, or Zofran)*	5HT3 Pregnancy Criteria: • Pregnancy related hyper-emesis exceeding one week. • Failure to respond to other medications, including at least a trial of pyridoxine and phenothiazines for the current pregnancy. • Has received IV re-hydration with imminent hospital admission if vomiting cannot be otherwise controlled. • Re-authorization requires review and approval by DUR board. 5HT3 Chemotherapy, Radiation, and Post-op Criteria: • Prevention of hyper-emesis associated with initial and repeat courses of cancer treatment with chemotherapy. • Prevention of hyper-emesis associated with radiation therapy in patients receiving either total body irradiation, single high-dose fraction to the abdomen, or daily fractions to the abdomen. • Prevention of post-op hyper-emesis. • Re-authorization requires a telephone request from the physician's office.
• Emend	Emend: • Used in combination with corticosteroid and 5HT3 agents to prevent acute and delayed nausea and vomiting associated with initial and repeat doses of highly emetogenic cancer chemotherapy including high-dose Cisplatin. • Patients receiving the following chemotherapy regimens that are classified by the National Comprehensive Cancer Network (NCCN) as high emetic risk may receive Emend as a first-line treatment: ‣ Cisplatin > or = 50mg/m^2 ‣ Cyclophospamide > 1,500mg/m^2 ‣ Dacarbazine ‣ Mechlorethamine ‣ Procarbazine (oral) ‣ Streptozocin ‣ Altretamine ‣ Carmustine > 250mg/m^2 ‣ AC combination defined as either doxorubicin or epirubicin with cyclophosphamide ‣ Patient must have failed on a trial of Zofran, Kytril, Anzemet, Aloxi, or other 5HT3 agent. • Initial authorization is for 6 months, 3 doses per chemotherapy session. • Re-authorization requires a telephone request from the physician's office.
Antihistamines, non-sedating *(Allegra, Clarinex, or Zyrtec)*	• Provide documentation stating when and how Loratadine or Alavert has failed. • PA's granted for up to 30 doses in 30 days. • Initial authorization period is one year. • Re-authorization requires a telephone request from the physician's office. • Children under the age of 10 may have Zyrtec liquid without a PA.
Arava	Arava: • Documented severe rheumatoid arthritis. • Documented history of treatment, incomplete response, or intolerance to Methotrexate. • Documented 6 or more swollen joints and 9 or more tender joints. • Documented rheumatology consultation within the last 60 days. • May not be given with other biological agents such as interferon, experimental medications or combinations. • Initial authorization is for 6 months. • Subsequent PA is for 12 months if the patient has at least 20% documented improvements in 4 of the following 6 areas: tender and swollen joint count, patient and/or global assessment of disease activity, pain, acute phase reactants.
Betamethasone Topical *(Luxiq, Olux)*	• Documented failure on generic formulations of betamethasone valerate creams or ointments within the last 12 months. • Initial authorization is given for 6 months. Subsequent authorizations require a telephone request from the physician's office or pharmacy.

Drugs Requiring Prior Authorization	
Celebrex	• Provide documentation of one of the following diagnoses: ▸ GERD ▸ Barrett's Syndrome ▸ Peptic Ulcer ▸ Gastro-hypersecretory condition or gastric bleeding caused by other NSAIDS (Documentation from progress notes is required). ▸ History of Ulcers ▸ Concomitant anticoagulant therapy ▸ Failure on 3 other NSAIDS (Documentation from progress notes is required) • Prior authorization is not required for age 65+ - see page 3. • Analgesia for 10 days will be granted with a telephone call from the physician's office or pharmacy. • Initial authorization is for one year - renewals require a telephone request from the physician's office or pharmacy.
Combunox	• Components must be unavailable separately. • A telephone call from the pharmacy or provider to the PA team is required. • Authorization is granted for a maximum of 4/day for a 7 day supply. • Re-authorization requires a new PA request.
Hepatitis Medications • Hepsera	Hepsera: • Diagnosis of hepatitis B. • Failure on Epivir. • 10mg/day is the maximum approved dose. • Initial authorization is granted for 12 weeks - renewals are granted in 12 month cycles with a telephone request from the physician's office or pharmacy.
Influenza Medications • Relenza • Tamiflu	Relenza: • Minimum age requirement: **7 years old.** • Diagnosis of Influenza A or Influenza B. • Covered only for patients at high risk from diagnosed and documented disease states of immunodeficiency. This includes HIV/AIDS or other diseases of the immune system; long-term radiation treatment; long-term treatment with drugs such as steroids, oncology agents, or immunosuppresive agents; or fragility due to extreme age (greater than 65 years). • Prior Approval is limited to one box of 20 amps per year. • **Treatment must be started within 72 hours of diagnosis.** Tamiflu: • Minimum age requirement: **1 year old.** • Diagnosis of Influenza A or Influenza B. • Covered only for patients at high risk from diagnosed and documented disease states of immunodeficiency. This includes HIV/AIDS or other diseases of the immune system; long-term radiation treatment; long-term treatment with drugs such as steroids, oncology agents, or immunosuppresive agents; or fragility due to extreme age (greater than 65 years). • Prior approval is limited to 10 capsules per year. OR • Prophylaxis for Influenza A or B for age 13 and older. • Documentation that demonstrates that one other household member or residential member currently has documented influenza A or B. • Covered only for patients at high risk from diagnosed and documented disease states of severe cardiopulmonary conditions, immuno-compromised patients, fragility due to extreme age (greater than 65 years). • Prior approval is limited to a 7-day course with 14 capsules. • TREATMENT MUST BE STARTED WITHIN 72 HOURS OF DIAGNOSIS.

Drugs Requiring Prior Authorization	
Irritable Bowel Medication Amitza	Amitza: • Minimum age requirement - 18 years old. • Diagnosis of Chronic Idiopathic Constipation. • Documented failure within the last 12 months using one fiber laxative and two stimulant laxative products. • Drug induced constipation must be ruled out. • Initial authorization is granted for 6 months - patient may have a second authorization after a trial off Amitza using other laxatives for at least 30 days. • The lifetime maximum is a total of 1 year of therapy with Amitza.
Invega	• Minimum age - 18 years old. • Diagnosis of schizophrenia. • No prior therapeutic failure on risperidone. • Not approved for use prior to trial of risperidone. • Patient fails to take multiple daily doses of anti-psychotics and cannot tolerate a single daily dose of risperidone. • Initial authorization may be granted for 1 year - renewal requires an updated letter of medical necessity.
Lactulose	• Documented diagnosis of chronic liver failure, hepatic encephalopathy, chronic portal hypertension, or Spina Bifida. • Prior authorization is only required for > 6000ml's per month. • This drug will not be approved for use as general laxative for over 6000ml's monthly. • Initial authorization is granted for 6 months - renewals require a telephone call from the physician's office or pharmacy.
Lamisil	• Documented diagnosis of onychomycosis. • Coverage will be limited to 16 months per calendar year.
Overactive Bladder Medications (Sanctura, Vesicare, Detrol LA, Enablex)	• Documented failure on short acting oral formulations of oxybutynin for 45 days within the last 12 months. • Initial authorization is granted for 1 year - renewals require a telephone call from the physician's office or pharmacy.
Oxandrin	• First 60 day trial period: ▸ Minimum age requirement - age 19. ▸ Adult onset AIDS wasting indication only. ▸ BMI is less than 20 - provide current height, weight and BMI. ▸ Patient must be taking antiretroviral, documented. ▸ Patient must be maintaining a nutritional intake. • Authorization after 60 day trial (may approve for an additional 4 months): ▸ All criteria above remains effective. ▸ Weight needs to have been maintained or has increased. ▸ If weight has not maintained, it is no longer a benefit. Patient may need to advance to growth hormone. • Subsequent authorizations are granted in 6 month periods, and require documentation that the patient's weight has maintained or increased. Provide previous weight and current height.

Drugs Requiring Prior Authorization	
Proton Pump Inhibitors	• Once daily dosing does not require an authorization - see page 7. • Prilosec OTC does not require a prior authorization for BID dosing. • Prior authorizations will be allowed for presenting acute states of GERD, ulcers, or hypersecretory conditions. • Documentation required includes a copy of an endoscopy report done within the last two years showing GERD or ulcers, or a copy of a hypersecretory study showing the hypersecretory condition. • Initial authorization is granted for two months. BID dosing for longer than 2 months requires special approval from the DUR board.
Provigil	• Minimum age requirement - age 9. • Covered for the following diagnoses: ▸ Narcolepsy - Amphetamines or Methylphenidate must be tried first. Dose is limited to 400mg daily. ▸ Treatment to offset sedation related to multiple sclerosis treatment modalities. Dose is limited to 200mg daily. ▸ Daytime somnolence due to obstructive sleep apnea - must be on C-pap. Dose is limited to 200mg daily. • Initial authorization is granted for 1 year - renewals require a telephone call from the physician's office or pharmacy.
Pulmonary Anti-hypertensives • Revatio	Revatio: • Documented diagnosis of Primary Pulmonary Hypertension. • Initial authorization is granted for 1 year - renewals require a letter or progress note indicating improvement or maintenance with the medication.
• Tracleer	Tracleer: • Minimum age requirement - 12 years old. • Documented WHO (World Health Organization) diagnosis of class III or IV Pulmonary Arterial Hypertension. • Copy of prescription from physician. • Contraindicated for patients with moderate to severe liver impairment and patients taking cyclosporin or glyburide. • Females cannot be capable of becoming pregnant. • Dose is 62.5mg BID for 4 weeks, increased to a maximum of 125mg BID. • Initial authorization is granted for 1 year - renewal request requires a telephone call from the physician's office or pharmacy.
• Ventavis	Ventavis: • Documented WHO group I NYHA class III or IV Pulmonary Arterial Hypertension. • Documented failure on Flolan and Remodulin and Revatio and Tracleer. • Not for simultaneous use with Flolan, Remodulin, Revatio, or Tracleer. • Submit a copy of the prescription from the physician. • Initial authorization is granted for 1 year - renewals require a telephone call from physician's office or pharmacy.

Drugs Requiring Prior Authorization	
Regranex	• Rule out venous ulcers and/or arterial ulcers. • Patient must be diabetic, either type I or type II. • Not covered for diabetic ulcers above the ankle. • Patient must have stage III or IV diabetic foot or ankle ulcer as per the International Association of Enterostomal therapy guide to chronic wound staging 1989. • Not a benefit for patients in long term care facilities, unless that patient is admitted from home or hospital with a pre-existing diabetic ulcer of the lower extremity. LTCF must submit a copy of skin assessment report made within 24 hours of admission. • The client must have had a documented failure on a 60 day regimen of good ulcer care that includes but is not limited to: 1. Initial complete sharp debridement. 2. A non-weight bearing regimen. 3. Systemic treatment for wound-related infections. 4. Moist saline dressing changes twice daily. 5. Additional debridement If necessary. • The subcutaneous ulcer may not exceed 3cm in diameter or total surface of 9.42cm^2 (size and shape must be documented). • Total contact casting is an available method of treatment and must be considered and rejected before Regranex is to be considered. • Initial authorization may be granted for 8 weeks and 15-30gm - renewal requires a second PA application demonstrating a 30% reduction in ulcer size. • Treatment is limited to 60gm of Regranex.
Renal Cell Carcinoma Meds • Nexevar	Nexevar: • Minimum age requirement: 18 years old. • Diagnosis of advanced renal cell carcinoma. • Initial authorization is granted for 400mg BID until no benefit or side-effects are intolerable - renewal requests are granted with a telephone call from the physician's office or pharmacy. • Nexevar is available only through 5 specialty pharmacies via mail-order: Caremark, Curascript, Accredo, Pharmacare, or McKesson Specialty.
• Sutent	Sutent: • Minimum age requirement 18 years old. • Diagnosis and documentation of advanced renal cell carcinoma. • History of other treatments, including documented disease progression on or intolerance to Gleevec. • Initial authorization is granted for 50mg daily, 4 weeks on and 2 weeks off. Dose increases or reductions by 12.5mg increments approved as needed or tolerated. Renewals may be granted with a telephone call from the physician's office or pharmacy.
Restasis	• Approved for the following diagnoses (ICD.9: ▸ 370.20 (Superficial keratitis, unspecified) ▸ 370.21 (Punctate keratitis) ▸ 370.33 (Keratoconjunctivitis sicca, not specified as Sjogren's disease) ▸ 710.2 (Sicca syndrome - Sjogren's disease) • Documentation requirements for the above diagnoses: 1. Diagnosis. 2. Documented fluorescein test. 3. Request from opthamologist or with documented opthamologist consult. • Prior approval for the above diagnoses is granted for 1 year - renewals require a new PA request. OR • Documented corneal transplant (ICD.9 V 42.5) • Initial authorization is granted for 1 year - renewals granted with a telephone call from physician's office or pharmacy.

Drugs Requiring Prior Authorization	
Retinoids • Panretin	Panretin: • Initial 30-day trial period: ▸ Diagnosis of cutaneous lesions caused by Kaposi's Sarcoma ▸ Documentation of primary number of KS lesions, estimated total square centimeters, number of lesions flat on baseline, and number of lesions raised on baseline. ▸ Systemic anti-KS therapy is not yet required. ▸ Retin-A 0.1% gel has been tried for a period of 60 or more days, and there was less than a 25% improvement of both partial response area and partial response height. • 60 day treatment period: ▸ Patient must sustain partial response defined as a 50% or more improvement from base line. ▸ Documentation of primary number of KS lesions, estimated total square centimeters, partial response area, and partial response height. • Re-authorization may be granted for additional treatment of 60 day periods with continued improvement documented as above.
• Retin-A	Retin-A: • Diagnosis of cutaneous lesions caused by Kaposi's Sarcoma. • Pre-pancretin use. • Documentation of primary number of KS lesions, estimated total square centimeters, number of lesions flat on baseline, and number of lesions raised on baseline. • Systemic anti-KS therapy is not yet required. • Initial authorization is granted for a 60-day trial period. Re-authorization is given for 6 month periods with documentation indicating that the patient has had at least a 25% improvement from baseline.
Stimulants for adult ADHD	Adult ADHD Stimulants: • Documented Diagnosis of one of the following: ADD, ADHD, narcolepsy, organic brain syndrome, traumatic brain injury, treatment resistant depression, mental retardation (if the patient exhibits injurious behavior, is hyperactive, or both), severe sedation due to psychotropic or chemotherapeutic medications. • Letter of medical necessity stating current treatment and situation. • Depression diagnosis requires a description of treatment history and failures. • Adult ADD/ADHD diagnosis requires a copy of the testing that has been done to make the diagnosis of adult ADD/ADHD. Acceptable testing for adult ADD/ADHD includes a psychiatric evaluation, Wender Utah Rating Scale scoring 46 or greater, documentation of the criteria that have been met from the DSM IV manual. • Statement documenting and substance abuse problems past or present, or a statement indicating no substance abuse history. • Initial authorization may be granted for one year - renewal requests require an updated medical necessity and an updated substance abuse statement.
Trizivir	• Documented failure of all three medications (Abacavir, Lamivudine, and Zidovudine) individually. • Initial authorization may be granted for 1 year - renewal requests require a telephone call from the physician's office or pharmacy.
Tykerb	• Minimum age: 18 years old. • Diagnosis of advanced or metastatic breast cancer whose tumor overexpresses HER2. • Prior therapy including an anthracycline, a taxane, and a trastuzumab. • To be given in combination with capecitabine. • Prior authorization is given for 1 year - renewal requests require an updated letter of medical necessity.
Xibrom	• Prior trial of any indicated medication. • Approved for one bottle for a 2 week period following procedure or surgery.

Drugs Requiring Prior Authorization	
Xolegel	• Minimum age: 12 years old. • Documented trial and failure of a generic formulation of topical ketoconazole within the last 12 months. • Prior authorization is given for 6 months - renewal requests require a telephone call from the physician's office or pharmacy.
Xyrem	• Age requirement - 18 to 65 years old. • Documented cataplexy associated with narcolepsy. • Documentation ruling out concomitant use of sedative-hypnotics. • Maximum dose is 9gm/day • Initial authorization may be granted for 1 year - renewal requests require a telephone call from the physician's office or pharmacy.
Zavesca	• Minimum age requirement - 18 years old. • Diagnosis of moderate type I Gaucher's disease. • Documentation that enzyme replacement therapy has failed. • Platelet count > 50k/ul (FAX a copy of the lab work) • Written consultation with a trained specialist (hematologist or geneticist) • Cumulative limit of 90 capsules in 30 days. • Initial authorization period may be granted for 1 year - renewal requests require a telephone call from physician's office or pharmacy.
Ziana	• Age requirement - 12-19 years old. • Patient must try and fail on a combination of both generic tretinoin gel and clindamycin gel. • Initial authorization may be granted for 1 year - renewal requires an updated letter of medical necessity.

Utah Medicaid Pharmacy Services

Request for Prior Authorization

Request Date_____

Patient Name_____

Patient DOB _____/_____/_____Medicaid ID #_____

Patient Address_____

City_____ State_____ Zip_____

Medicaid ID #_____

Drug Name and Strength_____

Dosage_____

Prescriber Name_____ National Provider ID_____

City_____ State_____ Zip_____

Prescriber Telephone#_____ Prescriber Fax #_____

Diagnosis:

Date of Diagnosis:

Attach Supporting Documentation

Total Pages_____

Instructions for submitting this PA Request

- Prior Authorizations are only accepted by fax.
- The form may be completed electronically or *legibly* by hand.
- It is not mandatory to use this cover letter; however all of the information requested on this form is necessary before a prior authorization request can be initiated.
- Fax all necessary documentation to the Medicaid Prior Authorizations Team in Utah County at the following numbers: (801)536-0964 or (801)536-0960 or (801)536-0959.

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